WORKERS' COMPENSATION INDUSTRIAL COUNCIL

JULY 12, 2010

Minutes of the meeting of the Workers' Compensation Industrial Council held on Monday, July 12, 2010, at 2:00 p.m., Offices of the West Virginia Insurance Commissioner, 1124 Smith Street, Room 400, Charleston, West Virginia.

Industrial Council Members Present:

Bill Dean, Chairman
Kent Hartsog, Vice-Chairman
Bill Chambers
James Dissen
Delegate Nancy Guthrie
Dan Marshall
Senator Brooks McCabe

1. Call to Order

Chairman Bill Dean called the meeting to order at 2:00 p.m.

2. Approval of Minutes

Chairman Bill Dean: The minutes of the previous meeting were sent out. Did everybody have a chance to look at them? Is there a motion to approve the minutes?

James Dissen made the motion to approve the minutes from the June 3, 2010 meeting. The motion was seconded by Bill Chambers and passed unanimously.

4. Office of Judges Report – Rebecca Roush, Chief Administrative Law Judge

Judge Rebecca Roush: Good afternoon. I'm here to tender the report of the Office of Judges for the month of June, and I e-mailed that to you this morning. I erroneously sent you the one from June, and I attempted to recall that. You should have before you the report dated July 12, 2010. The information contained within the report is substantially the same as last month. We acknowledged 437 protests in June. Outstanding pending caseload is 3,719 protests. Does anyone have specific questions about the report itself?

Bill Chambers: I have a question about the acknowledgement timeliness, which is item (D) on page three. As I understand it, these were acknowledgements of appeals that have been filed, and about one third of them take more than ten days. I am just curious, why does it take longer sometimes to acknowledge an appeal than ten to 15 days?

Judge Roush: That's a great question, and it is something that we may have discussed in the past. There are various reasons why. But most frequently there are issues with the carriers or sometimes they have not properly filed the appropriate electronic data/transmission information to the OIC. Our computer system requires us to put in a specific jurisdictional claim number before we can process it. To the best of my knowledge, most of the time when it is beyond the 30 days required to acknowledge a protest it is because of the reasons such as that one. And we work with the carrier to get the claim processed through the appropriate computer transmissions and get it set up, and then we can proceed forward with the acknowledgement. So it's really not an error on the part of our office per se, but there could be issues with the carrier's orders.

Mr. Chambers: And 30 days is the standard, or 30 days is the requirement?

Judge Roush: Yes.

Mr. Chambers: Have you ever considered making it 15 days?

Judge Roush: I have not. The Procedural Rule 93CSR1 and 93CSR2 has been intact since the jurisdiction of the office commenced in 1991. Of course it would be something for us to consider if the industry does in fact wish us to pursue that. We are in fact looking to amend our Procedural Rule so it's something we could consider.

Mr. Chambers: Thank you.

Judge Roush: You're welcome.

Kent Hartsog: Could I just follow-up on that?

Judge Roush: Yes, sir.

Mr. Hartsog: Could you help me understand the acknowledgement? What in fact are you acknowledging? Is it a protest from a claimant that you're acknowledging?

Judge Roush: Yes. The claimant will send a letter attempting to protest an Order from a carrier or a claims administrator [third party administrator]. Sometimes it doesn't have the appropriate reference material on it. Sometimes we do not have the Order. So that's the beginning phase of us receiving the protest, to put it into litigation. It's when they first contact us to set up an appeal.

Mr. Hartsog: So once they contact you then you send out an acknowledgement letter to them? What has to come together for you to do an acknowledgement letter? Let me ask it like that.

Judge Roush: We would receive a letter from the litigant [the protesting party] saying, "I wish to protest this Order from the third party administrator dated this date." If the Order was attached with the appropriate reference material where we could put it into our Case Management System, it would go along smoothly and it would proceed along. Then an Acknowledgement Order would come out with a timeframe establishing the deadlines for the submission of evidence before our office. So once that is concluded, once everybody gets the time to put in their evidence, then the claim is submitted for a decision, and then the decision comes out from the Judge.

Mr. Hartsog: So you not only have to get information from the claimant, you also have to get information from the denying party that they are protesting the Order to issue an acknowledgement?

Judge Roush: Exactly. Unfortunately our Case Management System is somewhat outdated, and it was in fact at one time tied into the old Workers' Compensation system where you could pull the claim information. We're working to update that as we speak. Hopefully within the next few months our Case Management System will be updated. But, yes, for the time being we do need information such as the carrier reference number, the jurisdictional claim number in order for our system to process the protest.

Mr. Hartsog: Thank you.

Judge Roush: You're welcome.

Chairman Dean: Mr. Dissen, do you have any questions?

James Dissen: No, sir.

Chairman Dean: Mr. Marshall?

Dan Marshall: No, sir.

Judge Roush: Just a couple more items that I wanted to bring to your attention. We are having some issues with a vendor who we hired to perform transcription services. Earlier this spring we were required [under the purchasing laws] to put out our transcription services for bid. We have been working very closely with the vendor to work through transition issues that they might have. Our previous vendor had been in place for quite a long time. I would say longer than ten years, so that process had run very smoothly. We have about 100 claims where there is a deficient transcript, and we are working with the vendor to have those transcribed appropriately. I met with the CEO of the company. They are out of California. I met with them last Friday and they gave me their commitment that they will do everything they can to correct the errors that we are experiencing. But I wanted to let you know – as well as some of the practitioners in the room – that you will see Orders coming out of our office with reference to these transcripts that are deficient, and we're taking every action necessary to correct the problems we're having regarding the transcripts.

Mr. Marshall: Judge, can you tell us if you've taken all the action that you are allowed under your contract with the vendor to force them into the level of performance that is required?

Judge Roush: Yes. I can reassure you we've taken every step imaginable. We worked with the Purchasing Division and the Department of Administration, as well as the OIC's in-house purchasing folks, and we have completed a Vendor Performance Form. But I will have to say, despite all the issues that we're having, I am comfortable in saying that the vendor acknowledged the errors, is remorseful for the errors that we have uncovered, and I do believe that they are going to step up to performing the contract as necessary.

Mr. Marshall: Has the situation caused a great deal of inconvenience on the part of either the claimants or the insurers?

Judge Roush: It has caused me a great deal of inconvenience, I can tell you that. We're doing everything possible to make certain that the litigation is not held up for the claimant. And, in fact, we are actually having some of our own staff re-transcribed the hearings. Unfortunately I believe what happened was the transcripts were outsourced, and they were not properly transcribed. I don't believe the people on the receiving end could understand or. . .let's just say the transcripts are obviously deficient. We've been told that there will be different folks doing the transcribing than the ones they had assigned to the contract previously.

Mr. Marshall: Perhaps it could be someone residing in the United States. Probably be appreciated by all concerned since the State is paying the bill.

Judge Roush: Exactly. I will say though that this is a limited number of transcripts. We were able to stop the matter from becoming much larger than it could have been, and it is a small number of claims that are affected. Nonetheless, it is important to note that they do need some help and we are doing everything we can to get it resolved expeditiously.

Mr. Marshall: Thank you.

Judge Roush: You're welcome.

Chairman Dean: Mr. Hartsog, questions?

Mr. Hartsog: No.

Chairman Dean: Mr. Dissen?

Mr. Dissen: No, sir.

Chairman Dean: Mr. Chambers?

Mr. Chambers: No, sir.

Judge Roush: I just wanted to say that we have our fall workshop dates tentatively scheduled that we hold every year. In Charleston the date is October 7, and in Morgantown the date is October 26.

Our renovations to our office are ongoing. It seems to be a never ending project. But we are making substantial progress in getting our hearing rooms moved up to the second floor, and hopefully we'll be able to invite you to an open house soon. Can I answer any questions? Mr. Chambers, I understand you have a question.

Mr. Chambers: With regard to the minutes from the April 29 meeting I just wanted to clarify. . .and I'm on page five of those minutes where you were talking about the rate of reversals of appeals relative to resolution of treatment issues. That paragraph reads: "This is the entire total for calendar year 2009. Again, we only reversed 25%. For the Old Fund there were 569 treatment issues; 24% were reversed. For private carriers,

the number is substantially similar. There were 408 treatment issues in litigation; 23% were affirmed." And I think we meant "23% were reversed."

Judge Roush: Yes, that's correct. I did have the opportunity to look at that with you just prior to the meeting starting. I do believe that it should correctly state "reverse."

Mr. Chambers: Thank you.

Judge Roush: Any further questions?

Chairman Dean: We'll move onto approval to final file Rule 22, Dan Murdock.

4. Approval to Final File Rule 22 – Title 85, Series 22, "Medical Review"

Mary Jane Pickens (General Counsel, OIC): I think Dan and I might tag team on this one. This would be the final action on Rule 22. Because this started some months ago, I wanted to procedurally rehash how we got here – to freshen everyone's mind. And then when we're done presenting this rule today, we'll ask the Industrial Council to final file the rule.

Way back in February this was initially presented to the Industrial Council and they voted to authorize the OIC to publish the rule for public comment. The rule was filed with the Secretary of State for public comment on the 23rd of February with a written comment period ending the 25th of March, which was the same day as the next Industrial Council meeting and the public hearing. So the public hearing was on the 23rd of March. We received – and I'm sure everybody recalls – many, many written comments, as well as a number of people spoke. Although I wasn't here at the public hearing, I think there were a number of folks that shared their concerns and thoughts about the rule. All of those comments actually were very welcomed. They were all carefully considered, and I think virtually every one of them was incorporated in some fashion into the rule. We felt that people had looked carefully at the rule and had thought about it, and we appreciated their comments, and they were good comments. And, again, we used most of them in the next version of the rule that was presented.

At the April meeting Dan Murdock (Associate Counsel, OIC), presented all of the comments received and our responses. But at that time there was ongoing efforts to work with the business community. They wanted to ask us questions. We wanted to make sure that we provided answers. Even though there was in-depth discussion and debate about the rule at that time, and the comments received, and responses to those

comments, we recommended at the April meeting that no official action would be taken on the rule so that we had more time to continue to work with the business community folks. There was no May meeting. I kept saying there would be a May meeting, but because of the way the dates ended the next meeting was on June 3. So at that meeting as well – because we had continuing discussion back and forth with the business folks – we had recommended no action at the June 3 meeting. So here we are in July. A lot of questions have been asked, and they are good questions, and we feel that we've provided a lot of responses. And we felt that it was appropriate at the July meeting that the Industrial Council consider the merits of the rule and vote one way or another on it.

To recap, this rule is called "Medical Review." The rule would require a review by a medical director or a physician in the event that an adjuster is inclined to deny a request from a treating physician in the following circumstances: A treatment request for surgery; a treatment request for durable medical equipment; a prescription drug request when the drugs or the medication has been received or previously authorized for 90 continuous days or longer and the medication was authorized within 90 days of an IME which the claimant was found to be at maximum medical improvement; and also the compensability of a claim or a specified diagnosis where the denial is based on a finding that there is no medical causal relationship between the alleged occupation occurrence or exposure and the alleged injury or disease. The rule defines "treatment requests." It intended to really make it clear and limit what a "treatment request" is and would require the OIC to promulgate a form. The other aspect of the rule is the acknowledgement in writing from the claim administrator that the request was received, which under the rule would be sent within 15 working days of the receipt of the request. Also, as a result of the comments – in the version that's before the Industrial Council today – we wanted to eliminate any confusion about the intent of the rule and we added some exceptions to the rule, which would be any treatment requests or prescription requests relating to the treatment of a physical or mental condition that affects a body part or body system for which no other diagnosis has been recognized in the claim. And then your duplicate – your identical requests – any request that's identical to a prior request that's already been denied in accordance with the rule.

So, again, there have been a lot of questions asked, a lot of information has been provided. The OIC put together a written response to a lot of the questions from the Industrial Council members and sent that out last week – I think it was Wednesday. And we went ahead and included it to the stakeholders, generally to make sure that everybody knew what information we were giving to the Industrial Council.

We want to emphasize that this is a rule that is triggered when an adjuster intends to deny a treatment request. It is not something that has to be done upon any request received. It's really only when the decision is to deny the request, not to approve the request. We also want to point out that a lot of treatment today is provided through managed care health networks – managed care health plans which have network providers. Under other rules those providers are allowed into these networks because they are trusted to only ask for treatment that's medically necessary and reasonable. There is ongoing utilization reviews for these providers to make sure that they are acting within the bounds that you would expect them to act if they're allowed to be in the network. If a treatment request is coming from one of these credentialed network providers we feel that the need for an adjuster to consult with a medical director is even heightened, and certainly not lessened.

We also want to make note of the fact that the insurance industry generally has not had a problem with this rule. Their only comment – during the public comments – was that we had originally said that a West Virginia licensed physician had to be the reviewing physician. We agreed that that didn't need to be in there, and we offered to change the rule consistent with that. The insurance industry recognizes this as a reasonable standard. It's a trend around the country. If anyone was going to be concerned about any costs or anything of that nature, certainly the insurance industry would have brought that to our attention.

From the Insurance Commissioner's Office, we want to work with the Industrial Council. We feel that we together are the group that needs to get the best public policy out there. We're the protectors of the system. We want to make sure that any standards that we propose are reasonable, certainly, and that the cost of any of those standards has been considered. In this case the opinion from NCCI is that the cost of this would be only negligible. We pressed them to try to put a dollar figure on it, and they simply weren't able to do that. They said it's negligible. Also, we want to point out that to the extent that litigation is reduced, where internal grievances are reduced, or that money is saved down the road because appropriate treatment is provided promptly in a claim. This compliance with this type of rule could actually reduce the costs. It's certainly not a forgone conclusion that there would be any increase in costs whatsoever.

Here we are in July. We are going to ask that the Industrial Council consider the rule, and we would urge the Industrial Council to vote to allow the OIC to final file the rule. We think that it is good public policy. It is a measurable reasonable standard. It will enable carriers and self-insured employers to know when they are in compliance with general statutory law that requires medical treatment to be reasonable and medically necessary. It's really something that we think should be welcomed as

opposed to resisted because it's a standard and it's not difficult to need it. It's not costly to need it. And if you need it, you know you're that much farther ahead with your regulator and with your litigation system, and that sort of thing. We really urge people to consider it as something that actually helps you make sure that you are in compliance as opposed to, again, resisting the rule.

The Insurance Commissioner is out of town on state business. She is not able to be here, and regrets that she's not able to be here because she feels strongly about this rule as well and has written a letter. Does everybody have the Commissioner's letter? And I apologize for the late notice of this, but Bill (Kenny) and I wanted everybody to take a few minutes to read it because if she were here she would say these things in person. Again, we apologize for doing it this way.

Chairman Dean: Do you want to take a minute to read the letter that's in your folder?

[There was a break in the meeting for the Industrial Council members to read the Commissioner's letter.]

Chairman Dean: Is everybody done with reading the letter?

Ms. Pickens: This concludes my introductory remarks unless Bill (Kenny) or Dan (Murdock) or Dr. Becker want to add something.

Bill Kenny (Deputy Commissioner, OIC): Let me just say this on behalf of the Commissioner. As you read from her letter, Commissioner Cline feels very strongly that we have an obligation to not only the employers who receive immunity from litigation from liability for workplace injuries because of the workers' compensation system, but more importantly we have a deep obligation to the injured worker. This is not like fixing an automobile – if you get it wrong you can correct it later. This is about fixing human beings. If you get it wrong you might not possibly be able to fix it later. We have many examples – and Dr. Becker is here to inform you of those – of decisions that were wrong that in a lot of cases would have been caught even if a nurse had looked at it before you even got to a physician, and it would have been overturned at the nurse level. We cannot continue to not do everything we possible can to make sure the injured worker gets the treatment that he is promised in the workers' compensation law. And that's what the Commissioner feels strongly about. We know this is not a financial burden to the system. We know that this is industry standards, that this is what takes place and should take place. We know that carriers do this because they are aware that by doing this you ultimately save dollars for the system. You get a better outcome,

and that should be a goal for everybody – employers and employees alike. Carriers do not necessarily do something that is going to cost extra dollars and not get results, so they are just fine with this system. We now use this system in the Old Fund. It was not done originally that way, but it is done now. We know that it's the standard as far as URAC is concerned. We see no reason why this should not be our standard. We also know that doing this will give all insurers, and self-insureds particularly, a bright-line – a standard of care to adjust their claims. Without this the standard that we will have to hold them to will be a standard that we will adjudge as whether or not they've met the statutory requirement of providing adequate medical care, without them having the benefit of knowing what that line is. We don't want to be in that position. We don't think that's a fair way to do it, but we do have to enforce the law that says "the injured worker gets adequate care." So we see no reason why this rule should not move forward. We've done everything we can to make sure it has as little burden on the medical system as possible. We did limit it to those cases that we know that if done incorrectly will probably cause the most harm that's irreversible. That's her stand on this and we really urge – for the sake of the human being involved in this that we don't allow. . . in 2009 I think it was over 350 injured workers that were not treated correctly. These are human beings. They are entitled to this by law and they are entitled to this by good standards. That's where we stand on it.

Chairman Dean: Dan, do you have any comments?

Dan Murdock (Associate Counsel, OIC): No, I don't.

Chairman Dean: Mr. Chambers, do you have any questions or anything you would like to bring up before we call for a vote?

Mr. Chambers: I think it's appropriate that we all express our feelings about this whether we do it now or as part of the vote. And so I'll be happy to go ahead and make my position known. I agree with the Insurance Commissioner that it seems to me that an average 24% reversal rate on appeal seems too high. It seems that we ought to be able to do better than that. But I note that for example the Old Fund, as Mr. Kenny says, has used this medical review for a while, but we still reverse 24% of those as well.

Mr. Kenny: We've used it about a year and a half.

Mr. Chambers: I have yet to see compelling evidence that applying this rule across the board will make a significant impact on that. I believe that, given that this system has gotten much better, that we need to be more targeted, more precise. I believe we need to understand more clearly under what circumstances, and who fails to

get this right, and how those reversals break down. I think there was a comment by somebody from the Insurance Commission in some of the early testimony that this appears to be some of the small companies, the newer companies to the market. If that's the case, it seems to me we could track that and we could be more precise. I congratulate the Insurance Commissioner and everybody for all they've done in the last couple of years. They've made significant improvements to the system. Given that I think we need to be more surgically precise as we continue to make further adjustments. Let me just mention the second. . .there are really two things in this rule that probably should be separated. The second one is the "notice requirement." While there is not statistics I do have a sense that we need to improve claimants' ability to know where they stand when something has been approved and when it hasn't been approved. So to me the notification that they be notified that a request has come in doesn't quite go far enough. But on the other hand the penalty that if we fail to notify them in 15 days – a standard that we don't use in other places – that the procedure is automatically approved. That seems too punitive for that notification. I can't support this rule, but I do support the Insurance Commissioner's view that both of those things need to be improved. I would call upon all of those people who are against this rule to come up with better ideas to help us improve in these areas in a more targeted precise way. And frankly if we can't do that, it won't be long until I'll be back calling for this rule to be put in place if we can't find a way to do better. But that's how I feel today about it.

Chairman Dean: Mr. Dissen, do you have comments?

Mr. Dissen: First I would commend the OIC's staff and the work that they have done over this six-month period. As you know I'm not a workers' comp practitioner, so I don't know all the nuances. We've discussed some of this. Where I'm left is reviewing the comments of the OIC and the general public. Basically the original goal of Rule 22 was to stop claims adjusters, non-medical professionals from denying claims, then the best practice argument was put in. From what I've read as to best practices now are adjoining states – Kentucky, Pennsylvania, Maryland and Virginia. I think Kentucky and Pennsylvania use this utilization process and have some of the higher costs, whereas Maryland and Virginia do not use it and they have some of the lower costs. So I think there is going to be a cost impact. We've also talked about the application of Rule 20 as only a guide or something more. When looking at that I thought somewhere in Rule 20 it says that the guidelines are to be given. . .I think "legislative weight" is the terminology they used. That tells me that it's more than just a guideline and it's something that can't be ignored. So maybe there's a duplication.

As to Rule 22, I'm still confused as to its purpose. And if it was what has been proposed or even addressed, as the issues I noted above, it appears we're trying. . .as

Mr. Chambers points out, it's a small problem with some employers placing an unknown cost on the backs of the entire employer community which still, according to statistics, may not solve the problem. And I've mentioned this before that the timing is a lot in making a rule change or anything, and this has attracted a lot of attention for this rule. But perhaps the National Health Care Legislation has made me a skeptic. But now when I hear a governmental entity who wants to make a change and the process has been working, and tells me that it's going to be negligible, it's not going to cost anything, or we simply don't know, that sends a red flag. You simply can no longer do that. Notwithstanding the tone of the recent memorandum, which I think is a matter we'll address somewhere else, I think there needs to be a more modest way of solving the alleged problem than passing a rule. Which as a Council member I have no idea if the rule is even needed, but more importantly what it's financial impact will be in order to protect the system that we talked about. So I don't think you made your case for me to support the rule. Thank you.

Chairman Dean: Mr. Hartsog. . .

Mr. Hartsog: Well I could go on with a lot of what my friends to my left have said. But when I looked at the April 29 statistics that we were given with regard to 2009, that 24% of Old Fund medical decisions were reversed, 23% for insurance companies and 24% for self-insureds, it seemed to be the same across the table even though the process that's contemplated in Rule 22 is imbedded in the Old Fund process, as I understand it. I struggle then to see how that solves the issue that we're trying to get out with more prompt better medical decisions being made without unnecessarily turning them down. With that being said, I've got this stack of paper, plus what's remaining in there is all this stuff basically we've gotten over the last six months in looking at it and talking about this particular rule. I think that we need to step back and perhaps get some more structured data. If Judge Roush would be so kind as to maybe – and I'm not sure what the timeline would be – to look at decisions for 2009 and 2010 with regard to denials and see if there is a common thread or something specific that we could look at. I would also like to hear from TPA's and insurance companies with regard to. . .what they would see would be an improvement in the system to not only provide good decisions but more timely decisions. I have heard consistently that it may not be the decision itself, but the fact it takes so long to get one. That also hurts an injured worker. That needs to be quicker. What can we do within the system to improve and get those decisions out faster? I wouldn't want to sit for two or three months and wait for a decision as to whether or not I can have some type of procedure or surgery or something like that. And a lot of that comes back to getting information out of the treating physician. So I don't know what the appropriate forum for that is – a public hearing or public input. On the other side too I would love to hear from the

claimant's point of view with regard to their experience and what some suggestions are on how that could be improved. Perhaps it's within the OIC itself. Perhaps it's with rule revisions that we need to make. Perhaps it's market conduct, targeted market conduct, depending on the results of what Judge Roush would come up with. Perhaps it's a combination of the above. I think there are definitely improvements there that could be made. I'm just not sure if this is the right approach given the stats on denials from 2009.

Chairman Dean: Very good. Mr. Marshall, do you have a comment?

Mr. Marshall: I have a brief comment. It's readily apparent what the sense of the majority of the Council is today, so I will be brief. I am convinced by the compelling argument made by the staff and the Commissioner that this regulation, when you set it down on purely cost benefit, the reasons for adopting it are compelling. All of the evidence that has been gathered – and I believe that you've gathered the evidence that's available in good faith – seems to demonstrate that the cost to the self-insureds or the carriers would be minimal if this regulation is adopted. And on the other side of that there is serious and substantial benefit both to the injured party and I think probably in cost savings as well to the providers to get these things addressed. To me there's something of a common sense issue in having an approved medical practitioner overruled by some insurance adjuster who is not a trained and licensed practitioner. That just doesn't pass the test for me. So I would support the rule as presented, and in that respect I'll respectively disagree with my colleagues on this issue.

Chairman Dean: Very good. I am going to speak a little different here as a construction worker. I've had two injuries in my life, both to ankles – broken ankles. The first time I think I could have done better if I would have had a second opinion. I could take my shoes and socks off and show you an ankle where the socket was broke, and they said it was a sprain. I didn't receive workers' comp for that. It happened at Lakeview Country Club in Morgantown. I didn't receive workers' comp for that because it was a sprain and they ordered me back to work. If I had been able to get a second opinion – because I was denied that – I think my ankle wouldn't be half as big as my other one today. The second injury I broke the same ankle. I was off work 12 weeks. I received no workers' comp for about 20 weeks and then I got it all in one check. And, again, I wanted to go to another doctor to get a second opinion and I never could do it. These are both West Virginia injuries. So as a construction worker – and feel free to pull my workers' comp records if you want – I think as a construction worker we have to have the right to try to get a second opinion. The first time I broke my ankle – I know the doctor – his name is Dr. Wilson. He was an intern that looked everything over for me. His father was an iron worker out of Parkersburg that I knew very well. To this day when I see Dr. Wilson we chuckle about it a little bit. I think this is a rule that we need

as a construction worker. We need to get a second opinion sometimes. I think if I would have had a regular doctor look me over rather than an intern [in residency], I would have been a lot better off. I am in favor of this rule just because I think it helps the people. I've not looked at it as a carrier. I think it helps the injured worker a great deal. Like I said, feel free to pull my workers' comp records if you want because I've had two injuries in my life. With that, that's my side on all of that. I'll show you an ankle that should have had surgery on it rather than just saying it was a sprain at that time. Does anybody else have comments?

Mr. Chambers: Let me just clarify. As I understand this rule, it doesn't give a claimant the right to a second opinion in and of itself.

Chairman Dean: I think it gives the claimant a right to get an opinion from the workers' comp doctor.

Mr. Kenny: A second doctor would look at it.

Chairman Dean: I think it gives you the right to have a second doctor look at it rather than just. . .like I said an intern told me I had a sprain, not a break. I think it gives you that type thing. . .that really I couldn't afford to pay for it to go out on my own. I should have, but I probably couldn't afford it at that time. I think that's what it does for you, Mr. Chambers, it gives you an opportunity to have a second opinion.

Mr. Marshall: Mr. Chairman, I want to clarify something. As I understand the rule, its applicability would be in the case where a treating physician prescribes a course of treatment or a durable medical device or medication. And then the carrier, or the third party administrator on behalf of a carrier or a self-insured employer without consulting a physician, but through the use of a non-medically trained adjuster, refuses to accept the course of treatment prescribed by the injured employee's physician. Now did I misunderstand it or is that a correct statement?

Ms. Pickens: I think that is correct. Your choice of words, "course of treatment," it's really more limited than that – its surgery, durable medical equipment, or the prescription drugs.

Mr. Marshall: Given that, I would say that this rule does less than give you the right to a second opinion. But what it does – and it is very limited in its application – if surgery for example is recommended by the attending physician and the carrier denies it through the. . .is not a physician but an adjuster without a medical degree, what this rule says is you can't do that. The carrier or the self-insured or the TPA has to have this

thing looked at by a physician – a licensed physician in some U.S. jurisdiction. Now I don't think that's an unfair burden when you lay that down beside the consequences to the injured employee. Therefore, I think this is a very well reasoned and sound regulation that deserves implementation.

Chairman Dean: Any other comments?

Mr. Hartsog: I'll just go back to what I'd mentioned before. I agree with you gentlemen except to the extent. . .I don't believe this does or think it will. If you believe the Old Fund rejection statistics that Judge Roush provided us on April 29, it shows this same number of reversals. In your case I believe your treating physician recommended that you go back to work with a sprain. There wouldn't have been a denial that would have been reviewed by a physician. And what I would like to do is target and address the time it takes to get a decision as well as the denials. And if there is a better way to get at those to improve those statistics. . .that answer. . .somehow a combination review by a medical person or by targeted market conduct reviews by the OIC, that in combination with better information that we're given with regard to why that issue is there, then we attack that problem and look at it. I'm just not convinced. I don't want to pass a rule and then say, "We solved that problem," and then find out six or eight or ten months from now that we basically have the same rate. Which, again, if you look at the Old Fund statistics for calendar year 2009, they mirror what they are for the self-insureds and the insurance companies. That's kind of what I get back to. Again, I would ask the Chair and I would ask the OIC to look at [in the Office of Judges] how we can put something together to explore those avenues to do something, be it a rule or be it by other measures.

Ms. Pickens: I have a couple of observations. First of all using the Old Fund as any standard of measurement is not advisable in our opinion. These are very old claims. They have a tortured history for the most part. Many of them have conditions that were never accepted in the claims, yet paying for things. As Bill Kenny mentioned, our TPA's have been complying with this standard, but they have been doing it briefly compared to the life of these claims. And by the time our TPA's got these claims, honestly, most of them were too far gone to do much with medically. So using the Old Fund and any reversal rate as an example for holding that up as an illustration of why this rule is meaningless, we would suggest it is not well founded.

The other comment I would like to make, everybody has proposed that we do something even better. It is always good to do something even better. But we don't think we should be guilty of throwing out the "good" in favor of the "perfect." Sometimes good is good, and sometimes it's okay to have good. You can still try to get perfect.

But in the meantime sometimes it's a good idea to do something that is reasonable and not burdensome, which we think this is. This was out for public comment. The Industrial Council, with our agreement obviously, has delayed action for a couple more months. If anyone from the business community had any other ideas about how to do it better, they have had ample opportunity to come forward during the formal comment period during the public hearing. They could have shown up at the last two meetings and offered their insights. Nothing has been proposed to us about how it could be done better. Honestly at this point, inaction on the rule appears to just sort of result in delay, and we can't see any real benefit in inaction at this point. Without this rule you've got the status quo, and the status quo is essentially that you litigate medical treatment denials. The answer is litigation. And there are costs and delays involved with that to both sides. But if that is the will of the Committee, then I suppose you should vote accordingly, noting that there is no motion. No one has moved the rule yet.

Mr. Kenny: Just to make sure that we are dealing with accurate facts here. Mr. Dissen mentioned that Virginia is cheaper and then concluded that perhaps this was going to be. . .and didn't use this system. You have to be very careful at taking one small particular item and saying, "It's what causes it to be cheaper." I think you would understand that there are lots of things different in Virginia, including the litigation system. But Virginia has a unique system. They don't use this type of system. But in a lot of cases the employee gets to choose his treating physician, either by himself or from a panel, and they have no official managed care in Virginia. And then the employer doesn't get to deny. That treating physician directs all the care. The employer does not have the ability to deny. So there is quite a difference. This will allow the employer to deny, but with some stipulations. This system, by the way, is pretty much. . .if there was a standard amongst the states, I'd say it's this. More states do it this way than not. Be careful about coming to the conclusion that Virginia is cheaper because of this particular system.

Mr. Dissen: I don't think I. . .

Mr. Kenny: I don't want anybody else to misunderstand.

Mr. Dissen: But in fairness, Bill, as I mentioned early on, I admit I don't know all the nuances, okay. So I read what the OIC staff puts together. I read what the practitioners and the general public put together, and there seems to be a conflict. In addition when we asked for the best practices of other states, I can look it up, but I believe the comment was, "Well, we really can't match apples to apples. There are some differences." So, apparently you know some of the nuances of Virginia, which I don't. So I base it on new material that you gave me.

Mr. Kenny: All I'm trying to do is make sure everyone understands it. I'm not trying to be argumentative about it. Secondly, I heard a comment that part of the problem is the length of time to make the decision. Obviously if we use a system such as this we do shorten the time because the length of time to make a decision is quite often driven by having to go through the appeals process, which lengthens it considerably. If you never have to get to an appeal for a decision, then you have shortened the timeframe.

As far as hearing from insurance companies, we have heard from insurance companies during the public comment period, and there was no objection to this type of system. They made one suggestion that we did agree with and that was it. From that standpoint we have heard from the insurance companies.

Now getting back to the 24% reversal. We don't know what we don't know. We don't know what's not been appealed, first of all. Second of all, what the reversal rate would be if this system was not widely used by carriers, and now by the Old Fund – which Mary Jane smartly pointed out – is probably not a good measure for anything when you are dealing with rules for the workers' compensation system. And we know from those statistics, for instance, that of the appeals, and not necessarily these – but appeals in general – that over 22% almost 23% come from the self-insured community. Yet the self-insured community is really just over 12% of our market. So we can draw from those conclusions that there might be a problem. It might not be from the carriers or from the Old Fund which is disproportionably lower than the appeals. There are lots of ways to look at this. It does get down to how many injured workers can be mistreated, and is that acceptable. Is that acceptable to treat a human being that way? And that's where we are on this. We firmly believe that this will help us. It's not the cure for everything. There is no silver bullet in this case. We just think it's unconscionable to allow an injured worker to be mistreated.

Chairman Dean: Dr. Becker, do you have a comment?

Dr. James Becker (Medical Director, OIC): Chairman Dean, I have a couple of comments. I'm addressing you both in my capacity as Medical Director here at the Insurance Commission and as a provider of workers' compensation care. I participate in the Ohio system through BWC and I also participate in Kentucky and West Virginia to a greater extent. I am really in favor of this rule. I think it is a step that moves us in the right direction. I think it will be impossible for us to know exactly how often inappropriate decisions are made in the claim management process. But the impact that it has on the providers is that what appears to be a frivolous decision by a claims adjuster quickly

sinks in with the medical provider and they decide not to participate in workers' compensation care. I believe it is safe to say that we are having more difficulty finding providers in some areas to take care of patients with workers' comp injuries despite the fact that we raised our reimbursement schedule. So that is concerning to me. And if I asked them, they have other complaints. But one of the complaints that they would list is frivolous decisions made by people who are not trained in medical issues related to workers' compensation. I've been looking at these as they come through as complaints, and this is purely anecdotal information. One claim that came to my attention was the replacement of a prosthetic limb that was rejected by the adjuster based on the fact that the patient had developed diabetes after losing the limb. And the necessity for the limb replacement came about because the patient had developed an ulcer on the stump. The claims adjuster issued a letter saying that it's denied because it is caused by the diabetes, not by the amputation. This person lost their limb in a mine, and we have an obligation to keep them fitted with properly fitted prosthesis. So that should not have happened.

The second one was a denial of coverage for seizure medication that was abruptly stopped because the patient couldn't afford the medication. The denial was issued by a claims adjuster who misunderstood the facts of the claim, and then the patient had a seizure six days later and went to the emergency room. By denying the medication that cost less than $50.00 per month, we spent $2,300.00 on an emergency room evaluation that included a CAT scan. So, there's some cost issues related to that.

There is a claim that's come to my attention of medical necessity for a neck surgery that was initially approved by the claims adjuster. But when they planned to do the surgery they discovered another problem with that patient and had to get that in control before they could do the surgery. The request for the surgery came from the Chairman of Neurosurgery at WVU. And yet when the patient was stabilized some months later the adjuster issued a denial that said it was because the patient had been able to get by without the procedure adequately during these months, thereby proving to the adjuster that the surgery didn't need to be done.

There are others, and I admit they are just anecdotal, but we cannot know how often it happens. In my opinion, what happens is that there is somehow a shift in cost when somebody really needs the procedure. I see patients shift the billing. . .shift the documentation so private insurance has to pick up the care that is inappropriately denied. And in cases where people don't have private insurance to shift it to, then those patients flounder around while they await the appeal process to run its course. Or they go to an indigent clinic and they try to get care under that system which delays their recovery, and eventually they don't return to the workforce. I think that is a burden that

we're trying to address with this rule. And I think while the rule may not be perfect, it is clearly a step in right direction and I am supportive of it.

With regard to your second opinions, we've addressed that in Rule 20. You can now get your second opinion while protected under that. That's mandated if you don't make an adequate recovery. Those are my comments.

Chairman Dean: Thank you, sir.

Mr. Hartsog: I would like to ask one question, doctor. One thing notwithstanding, what Mary Jane was discussing a few minutes ago. I'm sure you're very familiar with the Old Fund. The doctors there review any denials, as I understand it, before they go anywhere. Before they go out to the claimant they get reviewed, and the denial approved or a medical procedure or something within that bailiwick. Why would you see the reversal of denials by the Old Fund being as high or higher than the same percentage within the insured and self-insured group if this procedure is already in place?

Dr. Becker: Honestly Mary Jane's point about the complexity of these claims pretty much captures it. These claims have a tremendous amount of history associated with them. The TPA tries aggressively to manage the claim to reduce some of the medical costs on those claims. So if they see a window of opportunity to try to issue a denial, sometimes they overly aggressively deny medications that they are trying to work out of the claim or move people from a brand medication to a generic. And so by overly aggressively managing the claim to try to reduce them, you have more claims and claimants who are experienced in going through the appeal process. They go to the appeal process, and I think it is very difficult to make much of a dent in that just because of the history of those claims. That's how I would see it.

Mr. Hartsog: But isn't that the same as the self-insured or the insured community is with regard to just aggressive management which is what, if I understand you correctly, whether you have a physician involved or not. In looking at the denial you could still run into the same problem depending on what a particular insurance company or what a TPA does with the claim or how they see it or the person reviewing it.

Dr. Becker: Yes, I think that's a good point. The difficulty in reviewing these Old Fund claims is that frequently things that don't make a lot of medical sense have actually been ordered into the claim historically years before. And the effort to try to turn that around once you've paid for it – even if you paid for it incorrectly – is very difficult. The best example I could give you is years 2003 through 2006 when we tried

to control medical costs in the old Workers' Compensation Commission. We created a medical staffing of all the claims that had medical decisions that were possibly going to be denied. The Medical Unit, when I came in, was only reviewing about 600 claims using nurses. By 2006 we were reviewing over 3,000, sometimes 3,300 medical decisions a month. And that's much greater than any insurance carrier we'd see in our system today. But we were reviewing those and we were successful at least in reducing medical costs during that time by 27%. And that was by reducing the unwanted hospitalization, which was going to cost you much more by paying for an antibiotic or pain procedure medicine and eliminating some of the more high dollar bounce-back problems that occur in the system. That is one of the reasons that I'm so convinced that there needs to be some mandate for medical review of some specific denials.

Mr. Hartsog: But you have that in the Old Fund and you still have. . .

Mr. Kenny: We do now.

Mr. Hartsog: For the period that we're discussing here, Bill, I think for 2009 anyway the reversal of the denial rate was basically the same between all three categories.

Mr. Kenny: I think what you might have missed, what Dr. Becker was trying to say is any Old Fund claims – and again I hate using that as what should be typical of the going forward claims. But any Old Fund claims you saw a lot of. . .remember these are claims that dates of injury are prior to July 1, 2005. I think our average is 13 years old or something of that nature. You saw a lot of drugs that were authorized that really should not have been. I mean an awful lot of mismanagement – both sides. Too much care given to injured workers – inappropriate care or not enough. It was just inadequate. We put a program in about two or three years ago when we started having these reviewed medically that we called "wean taper." We did not allow the adjusters to merely say, "Ugh ugh, that should not be compensable. It's not related to your injury, even though you've been getting this prescription for the last 3 years, 4 years, 5 years," or whatever might be the case. We didn't want the injured worker to be cut off, especially with no other source of having that drug that they needed. The seizure one was of particular interest. I am familiar with that case. We get some disproportioned number of appeals for things that we cut off that we were probably right about. But when you look at the circumstances and the history of the claim, we lose our appeal. There is a lot of misinformation by strictly using the Old Fund. . .the insurance industry uses pretty much this same process. The only outlier would be that we don't know what the self-insureds are doing. We are concerned that the percentage of appeals that are

attributed to self-insureds are much higher than their market share. That's a concern of ours and we will be looking at that shortly. That is just something else contrary to this. But I think it is a bad assumption to say, "Well, it's the same 24%." You know, perhaps without this it would be 50%. Perhaps this system does work and it is helping given that the industry tells us this is what they use. We know pretty much the system they use.

I can remember when we first started working on the privatization, Mary Jane and I were at the AIG Claims Committee Meeting – their office is in D.C. – and we have as you probably know a fee schedule that says, "This is the maximum you can pay." And one of the claims managers looked at me and said, "As a regulator are you going to fine us or somehow penalize us if we pay a provider more than your fee schedule because the law says you can't?" And I scratched my head and I thought why would they want to be paying a provider more? Of course I asked the question and he said, "Well, look, if I get an injured worker who let's say injures his hand and needs an orthopedic surgeon, he really needs an orthopedic surgeon that is a specialist in the hand, not just an orthopedic surgeon. And he's not going to look at your fee schedule." But we know that if we provide the best care we possibly can early and we get that person back to work, ultimately that claim costs us less money. It's not that they wanted to spend more money. They knew that they would get the right outcome for the injured worker and at the same time save money. Well that type of thinking was not prevalent in the management of the Old Fund claims for all those years. And it was not until about a year and a half ago we finally got this working. In fact we actually did another reorganization about eight or nine months ago to put a nurse with every team of adjusters so they have a direct contact there. This is further improvement. It is really going to give you a false/positive so to speak, if you say, "Well, it's the same 24%." There are a lot of different circumstances. And I think that's what you were referring to when you were saying that these claims are mismanaged and have a tortured history. We are going to have more appeals because as we try to get it back in the best practices it causes that.

Chairman Dean: Any other comments?

Mr. Chambers: I'll put one more out there. With regard to the 24% of appeal reversals for the private fund, it is my understanding from prior testimony, etc., that the vast majority of private carriers do have some form of medical review. Whether it's a physician or a nurse, they have some form. If I could have seen statistics that show that those 400 that were reversed didn't have it, that would probably change my mind. But absent that, I have to assume generally speaking that a substantial number of those 400 did have a medical appeal and yet they apparently got it wrong and they got reversed. While the comparison to the Old Fund isn't the best, it's about all we've got in

the way of statistics because some of those 400 private carriers that got reversed must have had some. . .is it 10% of them or is it 80% of them? That would make a big difference, and I think that's why Mr. Hartsog and I would like to see some more detailed statistics so that we could more precisely attack this problem.

Mr. Kenny: If you're talking about insurance carriers, the vast majority is URAC certified, and URAC agrees with this process. Maybe some of the smallest of the smallest of carriers are not URAC certified. I know all of Sedgwick. . .every Sedgwick office around the country is URAC certified, and all large TPA's are. So I would say that the vast majority are. There are some outliers that aren't, but there is no standard right now for us to test for the market conduct exam – to what standard? The standard now is adequate care. Just as I don't think a medically untrained adjuster should be overruling a physician. I don't think my market conduct people who are trained in market conduct and that type of thing, not medically, should also be making a judgment. . .they've got that one wrong. . .not a standard I can test. I've got to have a standard. . .

Mr. Chambers: It seems to me if one carrier has 1% of the market – going back to your point about self-insureds – if they have 1% of the market and 50% of the reversed appeals, then somebody can take a hammer to those folks and do something about it.

Ms. Pickens: But that doesn't help those claimants. You could fine a carrier six months or a year later after they've done something. You can try to correct them going forward, but the claimant who should have had surgery within some reasonable period of time, and we found it later on a market conduct exam, isn't helped by market conduct – not that it's not a valuable tool. It's a very important regulatory tool. But this rule is geared towards up front types of assistance and not catching it later on. Even though we want to catch it later on, this rule has a different focus.

Chairman Dean: Any other comments?

Mr. Marshall: Just one. As I understand it, the carriers are not resistant to having this sort of bright-line test.

Ms. Pickens: Not that we know of.

Mr. Chambers: Didn't BrickStreet send a pretty strong letter in opposition?

Ms. Pickens: They had a lot of good comments that were incorporated – a lot of technical ways to improve the rule, which we agreed.

Mr. Kenny: Which we incorporated.

Mr. Marshall: Their comments having been taken into account, is it not your information that the carrier universe is not resistant to this bright-line test, point one. And the second point I would make is while we're all sensitive to the cost of regulation, nobody has come up with any evidence at all that the cost of implementing the proposed regulation is anything but minimal, not statistically significant. That's the only information we had. Now if we were to adopt this rule and the adverse consequences presented themselves down the road, we certainly have the ability to alter, amend, make changes as we deem appropriate. But we seem to be in a position here where we have a regulation that as far as we know is not going to be costly to implement and will directly and positively affect some injured workers who are right now subject to mistreatment. For those reasons, I think we should support it.

Chairman Dean: Very good. Any other comments? Seeing none, is there a motion for approval to final file Rule 22?

Mr. Marshall: I also move, Mr. Chairman.

Chairman Dean: Is there a second to the motion?

Mr. Chambers: I will second the motion.

Chairman Dean: Thank you, sir. Any questions on the motion? We'll call for the vote. All in favor signify by saying "aye." All opposed, "nay." It has been voted down three to two. [Bill Dean and Dan Marshall voted in favor of Rule 22 for final filing. Kent Hartsog, Bill Chambers and James Dissen opposed Rule 22 for final filing.]

5. Public Hearing on Rule 32 – Ryan Sims
Title 85, Series 32, "State Agency Revocation Or Refusal To Grant, Issue Or Renew Contracts, Licenses, Permits, Certificates Or Other Authority to Conduct a Trade, Profession Or Business To Or With An Employing Unit In Default Of Its Workers' Compensation Obligations"

Ryan Sims (Associate Counsel, OIC): We presented Title 85, Series 32, during the June meeting. It was presented as initial draft which will provide a new process for state agencies to direct potential licensees to apply or indicate that licensees have to come to the Insurance Commissioner to apply for an express letter that they are

exempt, and essentially setting up a new process just for state agencies to get an opinion from the Insurance Commissioner. We are doing this kind of parallel with the Title 85, Series 8 Rule that we previously presented, and is now awaiting finalization, and has been through the public comment process. There were concerns when we proposed eliminating that exemption process that particularly state agencies would have some trouble getting what they think they need from us. We presented this amended version of Series 32 in June, and it was approved for initial filing with the Secretary of State's Office. I can tell you I have received no public written comments on this. Today, of course, concludes the public comment period with the public hearing.

Mr. Hartsog: May I ask one question? Are you going to present both rules at the same time for approval by this group?

Mr. Sims: That is the intent. Assuming we get through this public hearing we will present them together for final approval.

Mr. Hartsog: My second question and my final one I promise. On Rule 32, is there any time limit that OIC will issue a letter, okay, that will basically. . .it will issue a letter to request of an agency with regard to whether or not insurance coverage is applicable based upon the facts you have in hand. Is there any timeframe that that letter is good for? Is it good for a year? Is it good forever or something like that?

Mr. Sims: Our current process with the exemptions is that anybody can apply. We have a year of process. It's not in the rule, but we just established it internally. So they apply for it. Once we issue the letter it is good for one year, and then we send them out something saying that they can reapply. I guess I really haven't thought about this, but I think for this new process we would essentially adopt the same kind of timeframe.

Mr. Hartsog: It will be good for what period of time?

Mr. Sims: Well, right now once we issue the exemption letter it is good for one year. In advance of that year being up we send them a notice that. . .I would have to have someone from our Employer Coverage Unit to be sure of the exact process, but it is something to that effect. We send them a notice out that it is about to expire.

Mr. Hartsog: But it is time dated?

Mr. Sims: It is based on our internal process. In Rule 8, which we currently operate under, there is no time set forth in Rule 8, but we set up an internal process using our discretion – time dated for one year – because, of course, circumstances can

change over the course of a year. And so we felt it would be internally appropriate to set up a process where it is good for one year.

Mr. Hartsog: Thank you.

Chairman Dean: Mr. Dissen, do you have questions?

Mr. Dissen: No, sir.

Chairman Dean: Mr. Chambers, do you have questions?

Mr. Chambers: No, sir.

Chairman Dean: Mr. Marshall, do you have questions?

Mr. Marshall: No, Mr. Chairman.

Chairman Dean: We're going through this quick. Does anybody from the general public have a comment on Title 85, Series 32? Seeing none, we'll move on.

Mr. Hartsog: Are you planning to bring up both of these rules at the next meeting for final filing?

Mr. Sims: I think there were only one or two comments on Title 85, Series 8, the rule that parallels this. So, yes, I think the plan is to bring both of them for final filing at the August meeting.

Mr. Hartsog: I appreciated you. . .you cleared up my concerns when you came back with this. Thank you.

[There were no other comments or questions on Title 85, Series 32.]

6. General Public Comments

Chairman Dean: We'll move onto to general public comments. Does anybody from the general public have a comment today? [There were no public comments.]

7. Old Business

Chairman Dean: We'll move onto old business.

Ms. Pickens: I just wanted to comment that following the special meeting of the Industrial Council where we discussed the draft of the Safety Study, the changes that were suggested and requested by the Industrial Council were made and we have electronically sent that information out. I think Mr. Hartsog had asked that we try to consolidate the insurance company responses into a shorter chart, which we did. And I think that has been provided to you as well. Today was the day that we wanted to file the Safety Study with the Legislature. But I just wanted to remind everybody that this is the day that we wanted to do it, and it worked out well because this is the day of the Industrial Council meeting. So if any final concerns or changes or reservations or what have you, if any of you have those, feel free to share them now. Otherwise it is probably going to go towards the end of business today.

Chairman Dean: Mr. Chambers, do you have any concerns on the safety study?

Mr. Chambers: No, none at all.

Chairman Dean: Mr. Dissen?

Mr. Dissen: No, they did a fine job.

Chairman Dean: Mr. Hartsog?

Mr. Hartsog: No.

Chairman Dean: Mr. Marshall?

Mr. Marshall: No, Mr. Chairman.

Chairman Dean: Do we need a motion to file the Safety Study for the record?

Mr. Dissen: So moved.

Mr. Marshall: Second.

Chairman Dean: A motion has been made and seconded to file the Safety Study. Any questions on the motion? All in favor signify by saying "aye." Opposed, "nay." The aye's have it. [Motion passed.]

Ms. Pickens: What you had in your binders from the special meeting was really a "draft." If you would like a final version – and you would probably do want a final version, an actual version of what has been filed – you could either bring your notebook back and we could switch it out or we could give you a new one. We thought if you brought your old one back and we switched it out it might be less confusing for you.

Mr. Marshall: On the other hand we have to carry it.

Ms. Pickens: That's true. You would have to carry it back.

Mr. Dissen: What's the concern about the [confidential] information if someone didn't want it? Where do we stand on that?

Ms. Pickens: That was Liberty Mutual. It was only on one bit of information that they provided, and I think Ryan Sims spoke with the gentleman.

Mr. Sims: There is one item that the gentleman that I spoke with at Liberty wanted stricken. It actually wasn't in the body of the report, but it was in some of the backup data, and we struck that. It was the number of insureds they have in West Virginia, which actually wasn't one of our ten questions. It was some backup information we requested at the beginning.

Mr. Dissen: I guess my real question is, from the report I have that's been stricken? That's not in it.

Mr. Sims: The final report doesn't have it.

Mr. Dissen: If it's lying on my desk and someone looks through it. . .

Ms. Pickens: Which might be why you want to bring your book back and switch it out.

Mr. Dissen: I'll bring my book back.

Chairman Dean: Does anybody from the Industrial Council have anything else they would like to bring up under old business?

Mr. Hartsog: At the last meeting I asked for some more detailed information under administrative costs in the Old Fund. Can we just put it down for the next meeting?

Ms. Pickens: We can. I've e-mailed back and forth with Melinda Kiss and they've been busy with some other things, and actually I didn't think about it again until just now. I did not follow back up with her.

Mr. Hartsog: That's fine. Next meeting maybe?

Ms. Pickens: Sure.

Mr. Hartsog: Thank you.

Chairman Dean: Anything else need brought up under old business?

8. New Business

Chairman Dean: Does anybody from the Industrial Council have anything under new business they would like to bring up? Mr. Chambers?

Mr. Chambers: No, sir.

Chairman Dean: Mr. Dissen?

Mr. Dissen: No, sir.

Chairman Dean: Mr. Hartsog?

Mr. Hartsog? No.

Chairman Dean: Mr. Marshall?

Mr. Marshall: No, Mr. Chairman.

9. Next Meeting

Chairman Dean: We'll move onto the next meeting. The next meeting will be Thursday, August 12, 2010, at 3:00 p.m. I've got a question for you on that. We met at 2:00 p.m. today. Is there a reason we have the meetings at 3:00 p.m. and not at 2:00 p.m. or 1:00 p.m.? I'm just asking.

Ms. Pickens: Don't we normally have them at 3:00 p.m.?

Chairman Dean: We always have them at 3:00 p.m. We had the meeting at 2:00 p.m. today and I kind of liked that, and I'm the one that travels the farthest.

Ms. Pickens: I think we just picked 3:00 p.m. and stuck with it and I honestly don't know why it's at 2:00 p.m. today, on a Monday I guess.

Mr. Dissen: You guys travel.

Chairman Dean: You work here locally.

Mr. Hartsog: No problem here.

Mr. Marshall: Two would be as good as 3:00 p.m. for me.

Chairman Dean: It's good for me, but I don't know about you all locally. So can we schedule the meeting for August 12 at 2:00 p.m.?

Mr. Hartsog: Would it be better for you if it was at 1:00 p.m.?

Chairman Dean: How is it with all of you if it was at 1:00 p.m.?

Ms. Pickens: We can work with whatever. I liked 2:00 p.m., but if you want 1:00 p.m.

Chairman Dean: I'm here at 10:00 a.m. on meeting day.

Mr. Hartsog: I'm fine with 1:00 p.m. or 2:00 p.m. If that helps you all in your travel and get back home at a reasonable hour.

Ms. Pickens: That's fine – 1:00 p.m.

Chairman Dean: Okay, the next meeting is Thursday, August 12, at 1:00 p.m.

Mr. Dissen: Do you want to modify that, Mr. Chairman, to say all future meetings.

Chairman Dean: All future meetings will be held at 1:00 p.m.

10. Executive Session

Chairman Dean: The next order of business is Executive Session. The next item on the agenda is related to self-insured employers. These matters involve discussion as specific confidential information regarding a self-insured employer that would be exempted from disclosure under the West Virginia Freedom of Information Act pursuant to West Virginia Code §23-1-4(b). Therefore it is appropriate that the discussion take place in Executive Session under the provisions of West Virginia Code §6-9A-4. If there is any action taken regarding these specific matters for an employer this will be done upon reconvening of the public session. Is there a motion to go into Executive Session?

Mr. Marshall: So moved, Mr. Chairman.

Mr. Dissen: Second.

Chairman Dean: A motion has been made and seconded to go into Executive Session. Any questions on the motion? All in favor signify by saying "aye." Opposed, "nay." The aye's have it. We will now go into Executive Session.

[The Executive Session began at 3:35 p.m. and ended at 3:55 p.m.]

Chairman Dean: I call the Industrial Council back to order. Is there a motion for the renewal of the self-insured status for the 19 employers on Exhibit A?

Mr. Marshall: So moved, Mr. Chairman.

Mr. Chambers: Second.

Chairman Dean: A motion has been made and seconded to approve the 19 employers for self-insured status. Any questions on the motion? All in favor signify by saying "aye." Opposed, "nay." The aye's have it. Motion passes.

11. Adjourn

Chairman Dean: Is there a motion for adjournment?

Mr. Dissen made the motion to adjourn. The motion was seconded by Mr. Hartsog and passed unanimously.

There being no further business the meeting adjourned at 3:57 p.m.